AZ Medicaid Outpatient Hospital Meeting

November 15, 2004
10:00 AM to 11:00 AM
AHCCCS 801 E. Jefferson St. – 4th Floor - Saguaro Room

Meeting Hosted By: Sara Harper, AHCCCS

Attendees:
(Based on sign-in sheets)

AHCCCS	BANNER	MMC
Mike Upchurch	*Richard Byrne*	*Karen Burns*
Lori Petre	**FLAGSTAFF**	*Kathy Gerlach*
Cia Fruitman	*Greg Kuzma (teleconfer)*	**PHOENIX CHILDREN'S**
Dora Lambert	**KINO**	*Susan Eggman*
Kari Price	*Jim Bands (teleconfer)*	**SCOTTSDALE**
Becky Fields		*Leslie Percy (teleconfer)*

1. Welcome (Sara Harper)

We are going to go through the final version of the claims and provider reference documents that were emailed to you on Friday and again this morning. We also sent out a copy of the flow chart that we are going to be walking through. Those of you on the line, check your email so that you will have all the documentation that we will be discussing, except for the examples.

Meeting participants introduced themselves.

2. Discussion of Flow Chart (Cia Fruitman)

The first page, which is the one with the fewer boxes on it, is how we are going to edit the claims as they come through. Obviously it will be a hospital bill type or a critical access hospital bill type. Outpatient or inpatient is the same day of discharge, which we pay at the outpatient rate. A good bill type will pass through the edits and examples of the edits that we are building into place are:

Is it a valid procedure code? Is the procedure to revenue code valid? If there is a modifier present we will be picking up to four modifiers on the UB. Is the modifier valid for that procedure code? Is the coverage for that procedure a covered code?

We are going to have a new table for limits, which is daily, weekly, and monthly limits for the number of units. This is similar to the way we currently process the 1500's. We are also going to put up a table for correct coding. Any questions on the edits? This is just an overview and we have more detail available on the edits in the big document.

Hospital Question: Are you going to be requiring ICD9 procedure codes on outpatient claims?

Cia: No, this is all going to run off of the CPT and HCPC procedure codes.

Cia: The flip side of the chart goes over how we are going to be pricing these. We are going to set up a bundled rate driver table. What that is is for certain procedure codes it will hit the bundling logic. We are bundling services for surgical and ER. If it is not bundled, it goes around the next couple of steps, if it is bundled it looks at the revenue codes that are bundled. Example would be pharmaceuticals. There is a table that is similar to Medicare, and there are a couple of exceptions that involve transplants. That is because all of our transplant stuff is separately contracted, so we exclude anything to do with transplants from this. If the revenue code is not bundled, we go outside to price. If it is bundled, then that line will

pay zero because we have built that particular cost of service into the rate. Then, they will pass down into the fee schedule that is built into the system that pays by code. If there is a rate available, it will pass down into the next piece. If there is not a rate available, it will apply the statewide cost to charge ratio. This is true for bundled and non-bundled. If the rate is available, it will multiply times the number of allowed units. Allowed units are up to the limit that was on that edit table I mentioned. If there are any modifier adjustments, it will apply the modifier adjustments. The next step it will apply the multiple surgery discount, and this is the logic that pays a 100% for the primary surgery and 50% for additional surgical services, unless they are exempt from the discount. Then it's going to apply something called the pier group multiplier. This is the percentage increase for rates that is being applied to the rural hospitals, public hospitals and children's hospitals. Then it will add up the amount for each line because it is pricing by line. Then if there is a penalty or quick pay discount, it will apply that last.

Hospital Question: Do you know what the statewide cost to charge ratio is?

Cia: Statewide cost to charge ratio right now is .2957, which came out October 1st, and that is the one we are using in the modeling.

Hospital Question: So an institution that has a cost to charge ratio of 60 would really get penalized here. Is that correct?

Sara: The fee schedule is designed so that five to ten percent of your total bulk of business is going to default to a statewide CCR. So in comparison to your previous CCR, if you have a higher or lower CCR, you are going to see an impact based on that. However, 90 to 95 percent of your business should be paid via fee schedule, so it should be a minimal amount that defaults to that CCR.

Cia: The sort of items that will be defaulting to the CCR, which are not used a lot, are the miscellaneous unspecified codes that usually end in 99, and if there is no procedure code on a revenue code line and it's not a required line, such as miscellaneous supplies, those are the only type of things that will go to default.

Sara: It's the exception rather than the rule.

Cia: Any other questions on the overall logic?

3. **System Requirements/System Proposal Status (Mike Upchurch)**
The first thing we will do is look at the ISD System Proposal Provider Reference. This proposal outlines the internal processes that we are going to follow to make some of these changes, but it also outlines the new tables and record formats that we will be providing for the plans and contractors to update their systems. The main thing today is that I cover what we are going to be changing from the way the status quo is now. If you will look at page six, we will start with a list of some of the new reference processes, tables and files that we will be generating in support of this. If you will look under the reference portion, where it has several bullet points, the initial one is that we currently have a maximum allowable table in the system, which takes care of all our processing. We have duped that over and are going to have one that is specific to the outpatient pricing system. Each of these tables that you are going to see here is outlined in the back of the manual from about page 24 to page 40. I'll cover some of them as we go through. We will have a new table for RF126 specific for outpatient pricing. We will be copying the procedure code indicator and value table will be RF127 now. Again, this is specific to outpatient pricing. Bullet point number three is how we update the rate schedules annually. That will not change and should not affect either the contractors or yourselves. The bi-monthly reference process includes RF113 and RF112. We currently place a file every month on the ftp server and make it available to everyone so that they can reference what information that we are using to process claims and encounters in the system.

Lori: That is something that we currently make available to the health plans. The intent is to establish another folder and make available to all the hospitals the password and ID so that you can access the files if you choose to do so. All the new tables plus some of the existing tables will be available to you.

ACTION ITEM Mike (?): Have an FTP folder created for the hospitals to access reference information.

Mike: All the file layouts are outlined in the back of the proposal, so you should have an easy way to decode the information. The key point here is the two new tables that we have outlined. The Outpatient Procedure Rate Schedule and Service Limit will be included in these bi-monthly updates now. That way you get a consistent look at all the platforms that we are working with. We will be putting in a new rate schedule, PGM, and Pier Group Multiplier in support of outpatient pricing system. We will have a new table in the transaction that will be added for bundled revenue codes. It will be date sensitive with begin and end dates. The new transaction will be RF796. We will have a new table for procedure codes that drive the bundling process, which will also be date sensitive. It will be RF797. A new table and transaction will be added to cross reference HCPCS to related CPT codes. These are also date sensitive. The key thing is to make sure we are not billing similar codes for same services. It is another step in the dupe process. The procedure add loop will be modified to include the new outpatient rate schedule. We also have RF789 that will be used to identify the multiple surgery exceptions.

Lori: Directly behind that is the milestone chart that we are tracking. There is a more up to date version, but when they publish these documents they publish the most current one then and update in the respect that it tracks when the meetings occurred. It has specific dates for the system development and our internal system and integration testing. It is something that we can make available to you. We are pulling some key dates from this. We are asking the health plans to give us their initial milestones and then how they are tracking their development. Once we get those, we will compile and share them with you. If you are dealing with a specific health plan, you will know where they are telling us they are within their timeline.

ACTION ITEM LORI: When health plans provide their milestones (development) to AHCCCS, forward to hospitals.

Sara: Another problem is the pilot testing with hospital and contractor partners is now starting February 1st. Initially it was slated for January 1st, but it has been moved. Last spring we asked hospitals if they were interested in being a pilot testing partner with us. One hospital indicated that they are interested in working with us. I haven't heard from too many others. Talk about it with your staff and see if they want to be testing partners.

Hospital Question: Do we have them contact you directly?

Sara: Yes.

Lori: We do have a website and email address and I will get that information to Sara so that she can get it to you. If you have any questions, suggestions or comments use that email address. It is monitored all day and we assign them to Sara or Cia to provide responses for a quick turnaround within a day or so.

Sara: We have asked the contractors to send us examples of particular claims that you are wondering how it is going to be processed by the new system. We have some examples of general claims, but if you have some that you are wondering about, we would be happy to have you send us examples through the partner testing process. Specific claims are great because that is what will drive it, actual procedure codes and revenue codes that are listed in order.

Hospital Question: Where are you getting the limits?

Cia: We have coding experts that will be setting those up. They look at national standards, and we have that sort of thing setup for our 1500's, but we see that the limits for outpatient might need to be different than the 1500's because you can have an outpatient that might reasonably need more labs within a day. It's a reasonableness check.

Hospital Question: So whatever exceeds the limit, will it be denied?

Cia: Yes. We are looking at the process that we will use to review them if they exceed. If you get them prior authorized, they will not be denied. The PA's will override the limit. If we setup limits that are not reasonable, you can contact us and we can review them and update them. Anything we update goes out monthly to the health plans and they can pickup any changes that we make.

Mike: There are several changes to the reference process being put into place. We are trying to keep everything standardized across both platforms (claims/encounters) so that if you are working on one and if you have both in your system, it will make it easier than it has been in the past. Some of the new screens we will be using, page ten, are the entity type that will show you the new rate schedule that we will be adding to PGM. We will use it to setup the payment schedule. What we want to do is go to page 31. One of the larger changes is the outpatient bundled revenue codes. This will be RF796. It will be setup based on begin and end dates so that we can tie all these processes together.

Cia: When you look at this, it is an example of codes. It is not all inclusive. Those are the codes that the services were bundled into the calculation of surgical and ER rates. Those are the only services we are bundling. A question we had in a different meeting was were we bundling radiology like Medicare does. The answer to that is "no." It is the range of codes from 9928, 1,2,3,4,5 are the ER codes and then roughly 10000 to 69999. Those are the surgical services range and those are the codes that will be bundled.

Sara: That has not changed since the initial documents that you received back in March where we had the listing of revenue codes. They have stayed the same with the exception of transplant related, which were pulled out because they are paid with a different mechanism.

Hospital Question: On all of these tables, like the filtered decision tree, you have edit examples of all the different RF's. All these tables will be available on the website?

Lori: Yes. In the new folder that we will setup for you.

Hospital Question: That will be available when?

Lori: The table structure will be done soon. We are relying upon Sara and Cia's folks to give us the values to populate those. Through testing we would like to make available some example tables so that you are getting them as early as possible with the caveat that they are not the final value.

Sara: We do not have all the values done at this point and time.

Lori: We have told the health plans that we would like to have at least a test version available to them no later than the first of the year, and sooner if at all possible. We will extend that same timeline to you.

Hospital Question: So the tables will be available January 1st?

Lori: That is what we are targeting. It may not have the final version of all the values, but it will be the structures and as many as the values in its final form as possible.

Hospital Question: When do we envision having the final values, because at the end of the day, the only thing that matters is the value, so when will those be available?

Sara: We will be working with these through testing and we want to get them done as soon as possible. Through testing we will find out many things.

Hospital Question: Do you think the majority will be final; there will be a percentage that is still hanging out there.

Sara: A majority should be ready and finalized when testing starts in February.   There will probably be some changes and adjustments made after that as needed.

Hospital Question: But certainly by the time we go live on July 1st?

Sara: Yes. I just can't promise how much ahead of that.

Cia: The only changes that will occur after that is every few months CMS has new codes, so we need to put in the new codes as appropriate. Those changes would occur after July 1st.

Hospital Question: So you mean as far as every three months CMS changes the payment structure?

Cia: They issue three update notices during the year, January, April, July and October to the HCPC codes.

Hospital Question: Do you mean the alphanumeric codes?

Cia: Yes.

Sara: We'll be updating as appropriate.

Hospital Question: Will it be once a quarter that you update? How do you plan on doing that?

Sara: I don't know that we have defined it at this point. Part of it depends on CMS. They do have a quarterly update and we would like to keep it to that if we can, but there might be some need to do it monthly.

Hospital Question: Are we supposed to track the updates that CMS is doing on the CMS website, or are you going to have something that you are going to send out to us to report the changes on the HCPC codes? How will that be conveyed?

Sara: I don't know. We haven't done this to this level of detail before. This is something we are considering right now. A lot of the things you are already going to know because notice is given to everyone.

Kari: How do you get them now?

Hospital: CMS website.

Kari: That would apply to us as well, as long as we are updating as often as CMS.

Hospital Question: So we can be confident that whatever CMS is saying, you are going to do the same?

Sara: That is what we are going to work on.

Hospital Comment: If you are not going to follow exactly everything that CMS is doing every three months and changing HCPC codes or A codes or J codes, then we will need some type of newsletter or notification or something sent out.

Kari: Your preference is that we stick as closely to the CMS changes as we possibly can.

Hospital Comment: If you don't plan on doing that, you need to put something out on the website or list serve that can be automatically sent to us.

Sara: We can probably put it on the ftp website. It is easier to put in all information and have one place.

ACTION ITEM: Sara to determine if the CMS changes will go to the FTP folder.

Hospital Comment: I would have to agree. I would prefer that you match CMS so that we can do both at the same time and if you do something different, please notify us.

Mike: On page 32 is the new bundled driver for the HCPC codes. It will work in conjunction with the table on the previous screen. It works like the CCI table currently, so it shouldn't be a big change to most folks.   The next thing is on page 38.   There are some modifiers that are setup to override specifically in the surgery realm. There will be certain associate surgical positions or billings that may be paid at 100%, instead of the 100-50 split. We have outlined in the claims documentation what the modifiers are, but those will be setup on this table. What it does is when it finds the modifier on this table, it will bypass the editing to split that second surgery into 50% and you will be paid at 100%. The next most important portion of the documentation goes back to page 51. It gives you the new layout for the files and batch processes that will be taking effect. The record layout that will be out on the ftp begins on page 58 and goes through page 60. As Cia mentioned earlier, you will have the outline for the bundled revenue codes, CTI codes, bundled drivers, outpatient pricing schedule, override modifiers, and multiple surgery exemption table. There is a lot of stuff in the first several pages that are internal to us, so don't let that confuse you. If you have any questions about what we say we are going to do, send us an email to the workgroup and we'll get back to you with an explanation. Any questions?

Hospital Question: Can you give us the email address?

Lori-Copied the sheet with the email address and provided to everyone.

Hospital Question: Once the folder is setup, will you notify us?

Sara: Yes, by email.

ACTION ITEM: Sara to notify hospitals when FTP folder is setup.

Hospital Question: Is there a place on your website with various questions and answers because maybe some of the other hospitals have the same questions that we do?

Sara: We can probably post that listing. It hasn't been updated lately, but that original list that I started was possibly posted in the contractor file.

ACTION ITEM: Sara to update question and answer document and have it posted to the web.

Hospital Question: Can you get the email address to someone at the hospital association so that it can be sent out to everyone?

Sara: Will do.

ACTION ITEM: Sara to send email address to the hospital association.

Kari: We will give some guidance as to where to go on the web.

Lori: I'll get the path for the web. It is under plans and providers, Outpatient button.

ACTION ITEM: Lori to provide the website address.

Hospital Question: So will you post the question and answer somewhere out there that we can find them?

Sara: Yes, it will be done but not this week. It needs to be updated with the questions that you have.

Lori: We are trying to keep a summary of what is opened that is still being worked on so that everyone is on the same page. We try as much as possible to post everything from each meeting.

Mike: The next one is the Claims ISD system proposal. Most of what you see in this document is in the encounters side. On page five, it shows under item 6.1, several of the programs that will be changing.

We will be changing the way we do dupe checks, the non tier service limits, the claim valuation, UB92 the non-tier valuation and the claim rate schedule lookup. What these documents do is refer back to everything that we discussed in the reference document. It tells you how we are going to use the tables that they've designed.

Lori: Tom mentioned in the meeting last month that it doesn't look like there are huge changes to the claims system to support this. That is because in the Hawaii model they do line item outpatient valuation currently. So, we were able to adopt a lot of those concepts and then modify them to read the tables that were setup to do this.

Mike: We have been doing that for over two years now.

Mike: On page six at the top, Claims Pricing program, is a walkthrough of the diagram that we went through to start with. It tells you that we are going to start performing checks on outpatient similar to what we do for 1500 bundling. The payment will now be based on the HCPC rather than the revenue code. For multiple surgeries, there will be certain surgeries that will continue to conform to the 100-50 split, but there will be certain items that will be paid 100-100 across the board.   There are a couple of different ways that these will be identified. One will be the modifier that can bypass the edit. The second would be the procedure codes listed on RF789, which will allow the surgery to bypass and will pay 100% for the second surgery.

Hospital Question: Are you going to be modeling your S and T indicators like Medicare, or will there by some variation?

Cia: It will be almost identical. The only exception is that if we go back and decide that there is a code that we should pay 100% that Medicare pays 50%. It will start out the same way.

Mike: Page seven addresses multiple surgeries. At the top there is critical claim edits. On page 12 of your document, it says bill type must be 100 to 147. It should be 148. Correct coding tells you that we are going to build a new table that will identify the codes that are not being billed concurrently like CCI bundling does now.

Cia: The correct coding tables are available on CMS website for the hospital CCI.

Mike: On page eight, outpatient late charge claims, bill type 135 will not be paid. They will need to be voided and resubmitted with the original claim.

Cia: This is similar to what you do now with inpatient.

Mike: The difference with the duplicate check process is we will be using condition code G0 instead of the admit hour in the dupe process. That is the only change to what we are currently doing. There is a list of modifiers that will not go through the dupe check process.   They are 25, 27, 59 76 and 77. On page 12 there will be some additional changes to the databases that will be done on separate SSR's and maybe separate timelines. At this point we are not sure. Those items will include being able to process up to 999 lines completely through the system, allowing the four digit revenue code, alphanumeric bill type and the different formats for procedure codes.

Lori: We will certainly share through this group and through the health plan group when the timelines are established so you will know when these items are introduced into testing.

Mike: Next is the list of some of the critical edits that are being used for what we have now and there may be additional edits added. At this point we are not sure, as we think we have the majority of them identified. There may be a few added, we will update and let you know by giving you a complete outline of exactly how they will be used and how they will affect you. A majority of what we identified is in here.

4. **Closing Remarks (Sara Harper)**

The last thing we have is a packet of examples. For those of you on the phone, you do not have this packet. We will send it out to you. I will get everything that we shared today to the hospital association so that for those that didn't come. We have ten examples of random actual claims that were gone over with the contractors, so this will be available to you also. They are very simple one item claims, some are bundled and some don't. It is just the general process showing how each line was priced. As I mentioned earlier, if you have specific examples of a type of claim that you frequently see, or the combination of codes, please see them to us. It is difficult to use generic examples that we have been given. Specific examples are most welcome.

Lori: Our approach to testing is to test at multiple levels and use as much live data as possible. This will allow you to assess and do some parallel comparison. You will be able to see what it did under the current structure and what it would have done under the proposed structure for both claims and encounters. We intend to do this with the health plans.

Sara: Any questions?

Hospital Question: Will all this be done electronically?

Lori: We will do some online, we'll do some electronic and a mixture of things. We may take the same claim and process it both ways so that everyone will have confidence.

Hospital Question: The hospital can do some testing, but not necessary electronic?

Lori: Any way they would like to do it. We are open to what is going to work best for everyone.

Hospital Question: Sara, what is your direct line?

Sara: My direct line is 417-4297.

Hospital Question: The document that I have with a version date of 8/5/2004 and these are 10/28/04, so is this presumably garbage?

Lori: Those were draft versions.

Sara: The ones I sent Friday and today, that is what we went through today.

Lori: Now that these are signed, any changes or additions or clarifications, they go through our change process so it will get a new version and it will be distributed to everyone and the new version will hi-light what the change is from the approved version. One of the things I know that I need to ask Mike to update in the Reference one is to setup the ftp folder for the hospitals, and we want to make sure that it is reflected in the document. There will be a new version that at least reflects that.

Sara: Any other questions?